



Critical Review of International Social and Political Philosophy

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/fcri20>

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To cite this article: Asha Bhandary (2021): The theory of liberal dependency care: a reply to my critics, *Critical Review of International Social and Political Philosophy*, DOI: [10.1080/13698230.2021.1922865](https://doi.org/10.1080/13698230.2021.1922865)

To link to this article: <https://doi.org/10.1080/13698230.2021.1922865>



Published online: 04 May 2021.



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ARTICLE



The theory of liberal dependency care: a reply to my critics

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ABSTRACT

This author's reply addresses critiques by Daniel Engster, Kelly Gawel, and Andrea Westlund about my 2020 book, *Freedom to Care: Liberalism, Dependency Care, and Culture*. I begin with a statement of my commitment to liberalism. In section two, I defend the value of a distinction between conceptions of persons in the real world and in contract theory to track inequalities in care when indexed to legitimate needs. I argue, as well, that my variety of contract theory supplies the normative content needed to reject the subordination of women of color. Acknowledging the enduring danger of expressive subordination, I emphasize my theory's compatibility with the full social inclusion of people with disabilities. Section three then defends *liberal dependency care's* compatibility with radical critique and transformative change by emphasizing the abstract nature of its core theoretical module. Finally, in section four, I reaffirm conceptual distinctions between autonomy skills, care skills, and a sense of justice by explicating their theoretical roles. In that section, I also embrace Westlund's insight that theorists of justice need to have skills enabling responsiveness to other perspectives. To this new requirement for actual theorists of justice, I further add that we must attain capacities to engage critically with our society's norms. Thus, the final section of this article supplements the justificatory module of liberal dependency care, building from the necessary conditions specified as two-level contract theory toward an account of necessary and sufficient conditions for this liberalism's justificatory module.

KEYWORDS Liberalism; contract theory; care ethics; disability; feminism; distributive justice; race; autonomy

I first wish to thank Daniel Engster, Kelly Gawel, and Andrea Westlund for their thoughtful commentaries. Engaging with them has enabled me to articulate some aspects of the view more clearly and to explore new conceptual and practical questions. As a general response to Engster and Gawel, who both prefer alternatives to the *theory of liberal dependency care*, I will defend my commitment to liberalism in [Section 1](#). Then, in [Section 2](#), I will respond to Engster's claim that the variety of social contract theory I endorse excludes the needs of persons with disabilities, responding, as well, to his claim that

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liberal dependency care 'fails to support decent care for all'. In [Section 3](#), I identify *liberal dependency care's* compatibility with radical critique and transformative change. In doing so, I refute Gawel's claim that my 'liberal theory of care, as illustrated in [my] autonomy-based procedural account of education, is incompatible with genuine social change in caregiving arrangements'. Finally, in [Section 4](#), I take up Westlund's invitation to explore connections between autonomy skills, care skills, and teaching youth a sense of justice.

Why I am a liberal

Because Gawel is critical of liberalism altogether, and Engster questions whether a mainstream form of liberalism such as mine can properly address care needs, I will begin with a preliminary defense of liberalism. I am a liberal because liberalism is the doctrine with the conceptual resources to identify when an individual's life energy is being grafted onto the substance of another.¹ Liberalism's conceptualization of individuals, with its positive valuation of individual autonomy, secures protection against exploitation at the theoretical level. As a new form of liberalism, *liberal dependency care* draws on core conceptual building blocks from John Stuart Mill, John Rawls, and Diana Tietjens Meyers. A central focus of my theory is the development of concepts that make the caregiving arrangement visible in order to then subject it to the critical evaluation of principles of distributive justice.

My two-level contract theory and the arrow of care map are responses to the problem that our intuitions about care are not yet correctly tuned. Before we can know if people will freely choose to act as caregivers, we must make more aspects of the arrangement transparent. In addition, we need to remedy the social distribution of skills and dispositions to receive and give care. Once these corrections are made to our skewed intuitions and abilities, we will have a better understanding of the nature of hands-on caregiving. It is at that stage – when the injustice embedded in existing choices to be a caregiver has been altered – that we can truly identify who autonomously wants to engage in caregiving.

Inclusion, disability, and a decent level of care

Engster questions whether my variant of contract theory can truly address the needs of disabled persons. To be sure, contract theory is considered inimical to the inclusion of people with disabilities. In comparison, capabilities and care ethical theories seem better able to satisfy the criterion that a just, and good, society must include disabled persons (Engster, 2007; Kittay, 1999; Nussbaum, 2006). Care and capabilities-based theories begin with the facts of human needs, specifying that a just society should meet these needs. On

this basis, they seem better equipped for the full normative inclusion of people with the full range of disabilities. However, they lack assessments of scarcity below the needed threshold, and tools with which to identify inequalities in the amounts of care that people are provided and providing, indexed by racial group.

For *liberal dependency care*, the possibility of scarcity is an objective circumstance of justice. One reason that we must maintain an understanding of the possibility of scarcity is because – although existing systems of social cooperation secure caregivers for some vulnerable people – the amount of care people receive, and the level at which our care needs are met, is not equal. The levels of care received are not equal in absolute terms, nor are these levels equal when they are indexed to our legitimate needs. Instead, social hierarchies enable members of privileged social groups to receive the care they need, and to go beyond that care to flourish and thrive. Translated into the racial hierarchies of the U.S., the needs of black and brown children are often perceived as less important than the needs of white children.

Therefore, although Engster and I share the aim that a just society is one where all people's needs for care are met, where this includes people with all abilities, I maintain the need for an assessment of distributive justice so that we can identify precisely how our real societies fail to meet this requirement. Because no society has ever met all of its' members' legitimate needs for care, we need conceptual and theoretical resources to identify when this outcome fails to obtain.

Many of the existing systems of practices that appear to meet the care needs of their members rely on a public understanding that 'justifies' the arrangement by conceptualizing the members of some group as naturally caring such that they simply want to care for others, or by denying them full claimant status. For instance, such a system of practices may rely on the falsehood embedded in the mammy stereotype, or on the social role of the daughter-in-law as caregiver to the family. In these cases, the Black woman in the U.S. or the Indian daughter-in-law in a patriarchal schema are expected to meet others' care needs, without limits on demands for their caregiving based on their own health, wellbeing, or choices. Consequently, it is essential to determine who incurs responsibility for meeting care needs.

In the *theory of liberal dependency care*, the needs of caregivers and people in social groups who are assumed to be caregivers take center stage. The demand to receive care, and the demand to provide it, are too often coded into social class, caste, race, and gender groups. Maintaining a steady supply of caregivers has involved naturalizing women as caring, the overt coercion and violence of domestic abuse, as well as moral pressure such as shaming people who do not want to provide care. It is for these reasons that *liberal dependency care* holds that an ideal that specifies a threshold of care received cannot be asserted without simultaneously asserting conditions of freedom

for caregivers. I insist on characterizing the agents of construction in the original position as self-interested to prevent absorbing the life energy of some people into the schema as a whole at the most foundational level of theory. If individuals are not recognized as distinct at that level, we cannot discern when interests should be combined. When contract theory advances a construction of persons to achieve certain pragmatic ends, as I do in liberal dependency care, that construction is not a description of real people.

Despite the way the discourse around contract theory has centered on the attributes of rationality and disability, I do not think that an assessment of distributive justice necessarily conflicts with the view that every society includes people with wide ranges of abilities and biological endowments, and that a just society responds to the needs of all of its members. What is needed to drive home that these desiderata are not in conflict is a cleaner separation among levels of theory, and between conceptions of people in the real world, as agents of construction, and in a just world.²

Notwithstanding my objections to the way the problem has been defined, it is true that the contract tradition faces technical difficulties about people with disabilities in virtue of the way persons are modeled as agents of construction. My solution to contract theory's technical question about how to include persons with disabilities is the Stark-Freeman solution (Stark, 2007; Freeman, 2013; discussed in Bhandary, 2020, p. 48). Perhaps the reason this solution is interpreted as inadequate for the full inclusion of persons with disabilities is because further emphasis is needed on the claim that people are conceptualized in different ways at different levels of the *theory of liberal dependency care* (Bhandary, 2020, pp. 86–87). Perhaps it is quite natural to jump from the way a person has been idealized to the conclusion that it states the ideal, and to thereby assume it serves as a description of everyone who is worthy. Furthermore, the fact that people with disabilities are sometimes devalued in the real world may leave little room for portrayals of people who are artificially idealized in ways that fail to capture the full range of human diversity in ability. Moreover, when violence against people with disabilities is perpetrated, it is done by people who may 'justify' their actions by placing them outside personhood, or beyond the community. All of these concerns are morally urgent, and philosophical theories are always vulnerable to misinterpretation or to being coopted by people who wish to perpetrate violence. More so than the capabilities or care ethics traditions, the contract tradition may be more easily interpreted in ways that harm members of the human community whose abilities and needs fall on the far ends of the human range, but my form of contract theory does not exclude any humans.

Moreover, these other traditions offer inadequate protection from exploitation for the population presumed to be caregivers. Therefore, to eschew *liberal dependency care's* assessment of the distributive justice of the caregiving arrangement is to rob the philosophical toolkit of a necessary – but not

sufficient – requirement with which to understand how to achieve a world that is just with respect to our needs for care.

Real people, agents of construction, and people in a just society

Engster characterizes my view as contractarian, but my view in fact mixes the importance of a moral idea of reciprocity with self-interested motivation in the modeling of persons (Bhandary, 2020, p. 45). I interpret the Rawlsian original position as a way of gaining critical distance from our intuitions, where it has contractualist elements. It is understandable to conflate the description of persons as they are modeled in the original position with claims about what people are like, or normative claims about moral status. But I take pains to differentiate these different levels of modeling, differentiating among the description of real persons in the real world prior to *liberal dependency care*, the characteristics of deliberators in the modified original position for *liberal dependency care*, and the characteristics of real persons in a just society structured by *liberal dependency care*. The reason that I retain self-interest at the level of modeling persons' motivations in the original position is to avoid grafting the substance of another at this very basic theoretical level.

The way people are modeled in the contract device does not describe real people, nor does it specify an ideal toward which we should aim. Therefore, its distance from reality and its limited purpose should mitigate against the danger of expressively subordinating people who differ from that model conception. I explain my views on this topic in Chapter 1, where I write: 'Although I maintain a broadly Rawlsian contract theory for *liberal dependency care*, my endorsement of social contract theory does not extend to a concomitant endorsement of the idea that rationality secures moral status ... (Bhandary, 2020, p. 50)'. Nor do I equate social contributions with a particular cognitive ability or involvement in the market economy. Instead, I hold that: 'liberal dependency care endorses the importance of reciprocity and the ability to share in the burdens of social cooperation, but it does not assume that rationality has a particularly high correlation with these contributions' (Bhandary, 2020, p. 50). The distinction between levels of theorizing enables inclusion of all human beings at a real, lived level, while requiring an understanding of productive contributions to track the possibility of scarcity in the domain of care provision. The latter consideration is included in the framework in a way that allows us to ask, for instance, when a Filipino man cares for an elderly white woman with Alzheimer's disease, whether he leaves his own mother's care needs unmet.³ These are among the reasons that I insist that an understanding of social cooperation that can identify distributive inequalities is necessary for transparency.

On the difference between fairness for a cooperative schema and unjust real world 'cooperation'

Of course, real world forms of 'cooperation' to secure care have often included prescriptive socialization, so that what seems (to some) to be a cooperative schema also includes a variety of coercive measures, including outright violence, microaggressions, and status hierarchies.⁴ Our cooperative schemas have typically relied on some subset of the community displacing their own needs in favor of the needs of others.

Rejecting the subsumption of some individuals into the cooperative schema as a whole, my theory of distributive justice establishes (at the abstract level of theory design) that each person counts as one, thereby providing conceptual and practical resources for identifying the exploitation of individual caregivers. To this foundation, I add a device for evaluating systemic patterns in care. A theory that begins with the claim that we should each *receive* the care we need, while neither acknowledging the possibility of scarcity of care provision, nor tracking inequalities in care *received* across populations, fails to yield adequate anti-racist conceptual resources. In the absence of a requirement for transparency of caregiving arrangements, and a flexible concept that can be used to track a variety of characteristics, we will not be able to find out whether some racial groups' needs are assessed as legitimate more often than those of others, nor will we be able to assess whether there are vast racial inequalities in the population of caregivers. Therefore, we need resources at the level of theory to identify who is receiving how much care, and to critically assess the legitimacy of needs. For example, *liberal dependency care's* evaluation of care provision at the level of system-wide patterns allows us to ask whether the needs for survival and flourishing of a white child with significant disabilities are met more often than the needs of a black or brown child with the same disabilities.

The process of identifying what counts as a legitimate need is a robust process. I begin to account for this process in my book by emphasizing the possibility of divergence between legitimate needs and what we assess to be legitimate needs. Because this is the passage Engster contests, I will reproduce it more fully here:

There are some clear cases of legitimate care needs. For instance, a person born with a severe cognitive or physical disability will legitimately require more care—care of greater intensity, sustained over more years—than a person without such a disability. Beyond the level of dependency care needed for survival, the amount of care a person will receive will be system-relative It is likely that the extent to which legitimate needs for care are diagnosed and met reflects existing patterns that are racialized, gendered, and reflective of social class. Consequently, assessments of legitimate needs must include resources for detecting variations in an individual's perception of their needs relative to the social narratives through which others interpret their actions. One way to

critically interpret an individual's sense of their own needs is to track ascriptive identity factors such as [gender] race and ethnicity in ways that acknowledge their connection to their history. (Bhandary, 2020, p. 92)

The assessment of legitimate needs requires the system-wide analysis enabled by the arrow of care map, which plays an essential role in identifying background understandings of needs and in identifying who is receiving care.⁵ For instance, consider racial differences in diagnoses of ADHD in the United States, where African American youth are diagnosed with ADHD at far lower rates than Caucasian youth, despite having more ADHD symptoms (Miller et al., 2009). In addition, Hispanic children and children of other racial groups are diagnosed at lower rates than white children (Morgan et al., 2013). An ADHD diagnosis provides access to medications that may improve school performance and overall functioning. Therefore, racial differences in diagnoses may lead to racial disparities in functioning. In addition, racial differences in diagnoses might reveal differences in the efficacy of parents as advocates for their children, where the efficacy may reflect the skills of the parent but also, and perhaps more significantly, the kind of uptake they receive when they raise concerns. Thus, access to these resources both manifests and reinforces racial disparities. In the U.S. today, the diagnosis of needs is already informed by racialized and often racist perception and frameworks. The arrow of care map dictates collecting data to look, first, at the numbers of children with the diagnosis, and then also to disaggregate the data by race. Further research is then needed to identify when two people with the same factual need are nevertheless assessed to have different levels of needs.

In conclusion, I think that eliminating the concept of reciprocity from an understanding of fairness in social cooperation, particularly when the labor that is performed by people of color is beginning to become visible in the 'account books' (Baier, 1994), would be to strip a vital metric from our assessments of justice. A just society must meet several criteria. It must fully include people with disabilities. It must meet care needs. And it must stop subordinating people of color and/(as) women to do so. We cannot merge the criteria together, for doing so makes it impossible to identify when conflict occurs.

My proceduralism and structural change

Gawel criticizes my proceduralism, arguing that procedural solutions do not secure transformative change. However, I think the proper target of her criticism is the social practices justified with a rhetoric of proceduralism and liberal choice rather than the kind of liberalism I develop. The form of proceduralism I recommend is 'strong' precisely because procedures cannot

eschew values altogether. Both the value of care and the fact that we live in an unjust status quo are initial premises in my argument, which results in the claim that caregiving skills be taught to people who do not possess the skills. Therefore, although I defend my proposal using the building blocks of liberalism, it has significant power to transform the status quo by teaching boys who are being raised to embody toxic forms of white masculinity to actually pay attention to the needs of others, and by holding them accountable for responding to those needs. The education required to teach these skills has the potential to change patterns of entitlement that influence the formation of the self.

Nonetheless, it is true that I endorse a form of proceduralism, and that my proceduralism leaves it open to people to make choices among a wide range of possibilities regarding the particular forms of care they want to participate in. This commitment to respecting the diverse autonomous choices people can make is a guiding value of my theory.

Engster, too, objects to strong proceduralism's licensing of individual choice with respect to significant caregiving responsibilities, finding it incongruous with my secondary proposal for conscription. The reason I endorse conscription *if strong proceduralism doesn't work* is because conscription avoids falling back on implicit pressures and social norms to secure a subset of caregivers. In the absence of clear guidelines for change, social inequalities find ways to revert to the status quo ante. In the real world, the people on whom the social system depends to provide care are often people of color.⁶ Therefore, an illuminating thought experiment for caregiving arrangements is to ask what would happen to the arrangement if people of color refused to be caregivers to white people. Because so much of this labor remains invisible and its traces permeate understandings⁷ about care, when we cease to assume that people of color will gladly provide care, we then realize that theories of justice must grapple with the possibility of scarcity in care providers. If – after the changes required for strong proceduralism – an inadequate number of people choose to be caregivers, a form of care corps could be put in place with policy oversight to monitor the race and genders of caregivers. A federal care corps program is better equipped to remedy concomitant racial patterns than a market-based solution that pays caregivers more.

Conversely, Gawel finds my liberalism too permissive of capitalism. Assessments of liberalism often pair liberalism with capitalism, or they conflate philosophical liberalism with practices of neoliberalism. My support for liberalism does not imply support for capitalism.

In addition, the theory of liberalism that I have developed does not commit itself to the practices of neoliberalism, where the latter doctrine includes capitalist and colonialist practices. Liberal political theory is sometimes impugned based on criticisms that are aptly directed toward neoliberalism

and/or the social forms where liberalism is the prevailing ideology, but the charges do not automatically apply to all forms of liberal political theory. I defend a liberalism that is based on the values of autonomy and individuality, and an understanding of justice as fairness. I insist on their value, without endorsing the idea of a corporate university or other such practices that are associated with neoliberalism.

Instead, my view is that there is a broad array of social practices that might be part of a society that is just with respect to care. A just society can have many forms. I argue for the need to think about care broadly, and in ways that do not assume the immutability of capitalism or of our particular gendered and racialized constructions of care. The arrow of care map, and the trimetric analysis for care create conceptual space to imagine a range of practices that could be compatible with a just society. I do not take on questions about how to modify markets in the book, viewing that as a separate issue, and as one with greater historical contingency than questions about how to structure care, because defining and structuring caregiving arrangements is universal and will forever be needed given the facts of human biology.

I also hold that the subject of justice is not coextensive with punishment, nor is it necessarily grounded in carceral logics. Instead, I understand the proper subject of justice as an evaluation of the fairness of the basic structure or, as I now prefer, in the more flexible language from Rawls's earlier work, as the 'system of practices' (Rawls, 1958). The primary subject of justice, on my view, is not law enforcement. Questions about how to respond to failures to comply should be addressed through a distinct module of theory.

When she evaluates the complexity of combatting violence in lived contexts of care, Gawel identifies an important subject, and one that is no less important than my book's subject, which is the distributive justice of caregiving arrangements. I agree with Gawel that activist and transformative practices and methods are needed to remedy lived injustice in ways that attend to the origins of the harm. The lived approach to interrogating practices Gawel espouses is a necessary constituent of moving toward a just world. However, transformative justice on its own is incomplete if it occurs without a background account of distributive justice, where that background account of distributive justice must include the arrow of care map as a conceptual tool with which to structure inquiry into care relations. Correspondingly, the arrow of care map is a tool for radical critique of existing caregiving arrangements and the cultural forms, self-understandings, and patterns of behavior that supervene on them. It is my view that the arrow of care map critique must be an ongoing part of the effort to move away from unjust social arrangements. The tools of abstraction are needed precisely because the relationships where care occurs can be sites of, as Gawel asserts, 'trauma, abuse, and interpersonal violence'. However, contrary to Gawel's claim that my theory precludes structural change, my theory calls for an assessment of the structures of

care that seeks to attain distance from our skewed intuitions about them. In this way, the ideal theoretical module is a source of radical critique.

Moreover, the aim of attaining justice in care will not be achieved without a background module evaluating its distributive justice, which is the primary contribution of my theory. Therefore, I reject the claim that my view is incompatible with these alternative forms of critique, although I leave open a definitive verdict on their precise relationship.

Overall, Gawel's thoughtful commentary delineates the boundary between the subject of my book and the additional work needed to evaluate, identify, and participate in real world requirements for justice and activism. My proposal for strong proceduralism, and my defense of caregiving skills, are my primary, and deliberately scant, interventions in that domain. Prompted by Westlund's comments, next, I will advance some additional claims with proximate practical implications.

On autonomy and care skills

My defense of autonomy skills has the form of a legitimacy condition for two-level contract theory. It identifies how a theorist is connected to the world, but it does not offer a full account of the requirements for a theorist of justice. In my book, I write that 'my focus is not to identify criteria for the theorist; that is a separate project for social epistemology' (Bhandary, 2020, p. 97). Therefore, I welcome this opportunity to specify these criteria for theorists of justice, prompted by Westlund's commentary.

Westlund suggests an additional requirement for theorists of justice, and it is one that I accept to augment my two-level contract theory. She proposes that theorists of justice themselves need to have skills with a 'dialogical or relational structure, and include skills involved in theorists' responsiveness to other perspectives, as well'. In addition to the dialogical responsiveness Westlund proposes, theorists of justice need critical capacities about how current social arrangement influence intuitions, or what Jose Medina calls 'metalucidity' (Medina, 2013). The latter condition results from the recognition that justice is about a society of real people, and determining what will be fair, and thus just, requires the input that results from dialogue.

Evaluating connections between autonomy skills and care skills

My book argues that, as a matter of legitimacy, widespread possession of autonomy skills is needed in the real world so that people can identify – in order to then reject – social arrangements that fail to grant them equal standing. Westlund identifies the reverse phenomenon, which is that some people may need to decrease an outsized sense of self-worth. Whereas my argument is based on the need for people to be able to stand up for their own

interests, and to be able to identify what those interests are, Westlund addresses a different audience. The two groups that serve as most salient in our analyses are linked precisely through social forms structured by deep and sedimented inequalities, in which hierarchies are relational. Westlund identifies the practical and moral significance of social hierarchy when she argues that teachers need to convey a background conception of the equal worth of persons to students. As she states, 'For some, this will perhaps involve heightening their own sense of self-worth, while for others, it will involve paring down an outsized sense of worth that overshadows receptiveness to the claims of others'. There is indeed a connection between our views, and I agree with Westlund that learning attentiveness and responsiveness can deflate an outsized sense of worth.

However, I resist Westlund's proposal that possessing autonomy itself might require care skills. Her view is that attentiveness and responsiveness to others may well support autonomy's dialogical aspects. Despite her compelling independent argument for a dialogical account of autonomy (Westlund, 2003), I prefer maintaining conceptual separation between care skills and autonomy skills. The reason for this separation is because, for some, adjusting one's intuitions so as to be just requires paying more attention to their own needs. For people on the other side of these social hierarchies, though, being just requires making room for the needs of others, which also requires making room for others' perspectives. To truly make room for the perspectives of others, people who are relationally privileged must identify how their/our entitlements, freedoms, and affordances are dependent on the unfreedoms of others. In fact, someone engaging most earnestly in this endeavor may arrive at a self-understanding in which he learns that his expectations from the world and others are illegitimate because they are predicated on injustice.

A caring person is aware of the needs of others and acts to balance them against their own needs. My proposal to teach caregiving skills to boys may therefore attain the desired effect of decreasing boys' outsized sense of their own worth. But a caring person can also lean too far toward caring about others in ways that result in harm to their own health, which may also result in resentment that manifests as anger toward people who rank below them in the local social hierarchy. Moreover, although caregiving skills are the skills needed to care for another person, they are not sufficient to undo racial patterns of concern and disregard. Once people possess caregiving skills, they can still selectively animate them. The phenomenon of caring members of one racial group displaying excessive disregard for people in an 'other' racial group points toward the linked phenomena that people are selective about their concern and skills can be selectively activated. For example, under conditions and racism and patriarchy, the caregiving and other-directed attention assigned to white femininity can be combined with white

entitlement and a lack of concern vis-à-vis the lines of race to result in acts of hostility and various forms of violence against women of color by white women. Therefore, because people can be highly selective about who they are attentive and responsive toward, simply learning autonomy and care skills will not be sufficient for a person to also possess a sense of justice.

On the distinction between teaching a sense of justice and autonomy

Westlund also perspicaciously points out that critical thinking education in schools today leaves many students impervious to the perspectives and needs of others. As a remedy, she defends an 'imperative that individual opinions or world-views be subject to intersubjective standards of evaluation'. These are important aims. So too is Dearden's principle requiring that we proportion our confidence in a matter 'to the epistemic likelihood of it being true'. Nonetheless, for the reasons listed above, I resist subsuming these principles into the content of autonomy education. Autonomy is a kind of self-governance that is closely linked to being able to identify and represent one's rights and needs. In this way, it is a self-regarding capacity. And it is but one piece of a good life. A person who resists intersubjective standards of evaluation fails in a moral sense. It does not follow, though, that they are not autonomous. Contrary to Kant's influential account of autonomy, I hold that autonomy is not a form of *moral* self-governance; it is not governance in accordance with rationality and thus moral law. Instead, its central ideas are governance of the self and a kind of individual freedom. Correspondingly, an autonomous person is not necessarily a just or good person. They are good in one respect, in that they are autonomous, but the status of the person as autonomous is not constrained by the criterion of goodness. For instance, a person might possess a high degree of personal autonomy while being selfish, unaware of their broader impact on others, and immoral. Because the essence of autonomy is guiding one's own life, it is an ideal that does not specify the entire ideal of a good life, or of well-being, or of being a good friend, community member, or companion. Personal autonomy is a partial ideal of a good life, and it does not guarantee that the person who displays it will be just.

Therefore, although I largely agree with Westlund on the value of subjecting oneself to intersubjective standards of evaluation, and also on the related claim about the importance of a kind of dialogical responsiveness to others as a component of a sense of justice, I maintain the distinction between intersubjective standards of justice and the idea of autonomy. What follows from my exclusion of justice from the idea of personal autonomy is that we need an additional educational requirement for societies seeking to be just, which is that they must teach citizens a sense of justice. The education Westlund suggests, involving epistemic responsibility toward standards, is a sound

recommendation for a curriculum to teach a sense of justice.⁸ In addition, education for justice will need to teach students about currently prevalent norms and stereotypes and one's relationship to them.⁹

Conclusion

In this brief reply, I hope to have done justice to my critics' explorations of, and challenges to, my theory of *liberal dependency care*. In doing so, I have also sought to convince readers – including those who may be skeptical about the value of liberalism – of the indispensability of this form of liberalism as a theory of the distributive justice of the basic structure, where that basic structure necessarily includes caregiving arrangements. As for those comments that I have been unable to address here, their imprint will undoubtedly be discernible in my future work.

Notes

1. For the original source of this usage of 'grafting' another onto oneself, see Frye (1983, p. 66), for whom it is part of arrogant perception. I employ it in Maria Lugones' sense, who explains that she grew up in Argentina seeing people graft the substance of servants onto themselves (1987, p. 4).
2. For further elaboration, see the next section.
3. It is compatible with the idea of 'global care chains' (Hochschild, 2000).
4. For substantive assessments of the relationship between contract theory and racial and sexual domination, see (Mills 1997; Mills & Pateman 2007). Their accounts overlap with, but differ from mine, for which caregiving arrangements are the salient organizing principle.
5. The arrow of care map should be employed in what Nancy Fraser calls the 'interpretive justification' (Fraser, 1989, p. 312) of needs.
6. In the U.S., of course, gender is another significant sorting factor for caregivers. My theory is a framework with which to accurately capture the variability of caregiving arrangements across contexts and countries, with the concepts 'customary care practices' (116) and 'the arrow of care map.'
7. Here I use 'understandings' in Walker's (2007) sense.
8. Perhaps a sense of justice would simply arise from living in a just society. See Rawls (1999, Section 86). In the meantime, though, a sense of justice should be taught.
9. The content of this education should be inspired by Jose Medina's account of metalucidity. According to Medina, 'Meta-lucid subjects are those who are aware of the effects of oppression in our cognitive structures and of the limitations in the epistemic practices (of seeing, talking, hearing, reasoning, etc.) grounded in relations of oppression: for example, the invisibilization of certain phenomena, experiences, problems, and even entire subjectivities' (Medina, 2013, p. 192).

Acknowledgments

In addition to my appreciation for Daniel Engster, Andrea Westlund, and Kelly Gawel's thoughtful engagements with my work, I am hugely grateful to Amy Mullin for her editorial expertise. My thanks also go to Diana Tietjens Meyers and Tamara Metz for their valuable referee reports. These articles originated in an Author-Meets-Critics session in February 2020 at the Central American Philosophical Association meeting in Chicago, and I thank the program committee for organizing that session. Finally, I thank CRISPP's editor, Richard Bellamy, for his support for this symposium.

Disclosure statement

No potential conflict of interest was reported by the author.

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